



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

June 13, 2014

Public Health & Emergency Preparedness Bulletin: # 2014:23 Reporting for the week ending 06/07/14 (MMWR Week #23)

CURRENT HOMELAND SECURITY THREAT LEVELS

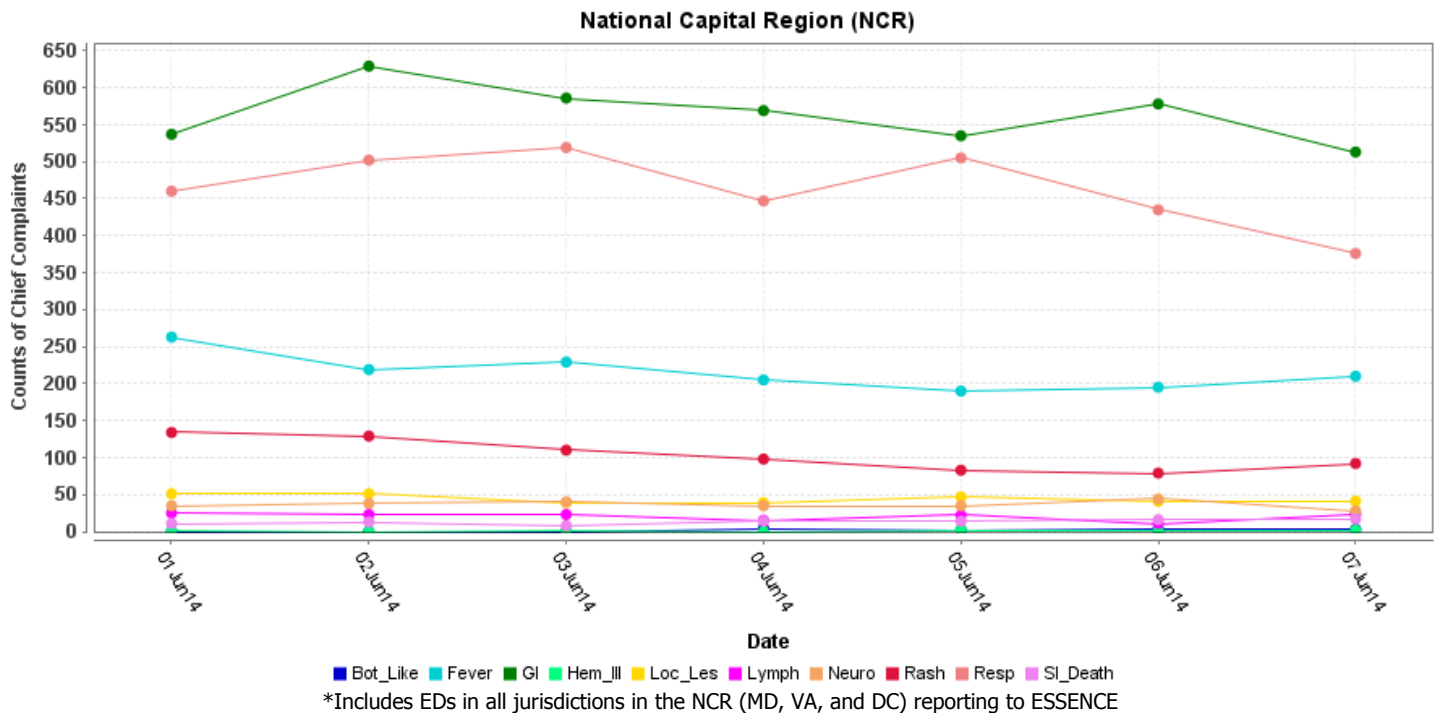
National: No Active Alerts
Maryland: Level Four (MEMA status)

SYNDROMIC SURVEILLANCE REPORTS

ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):

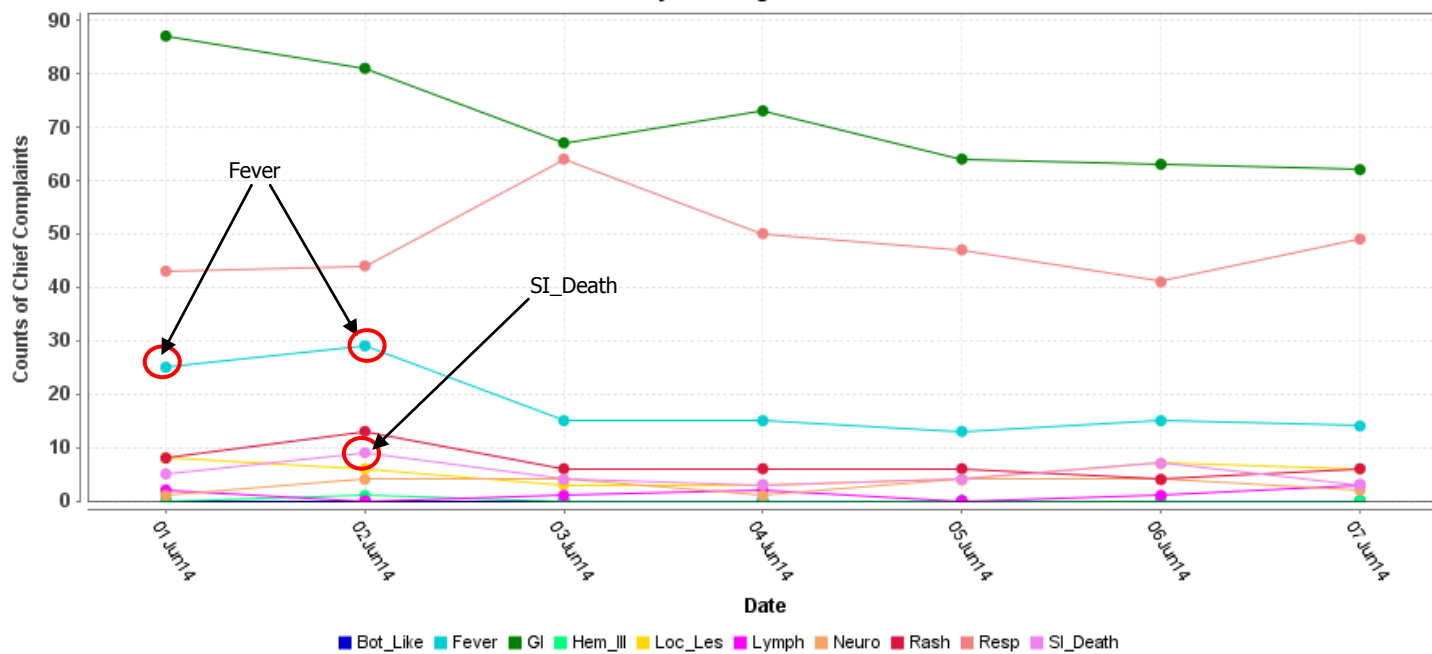
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.



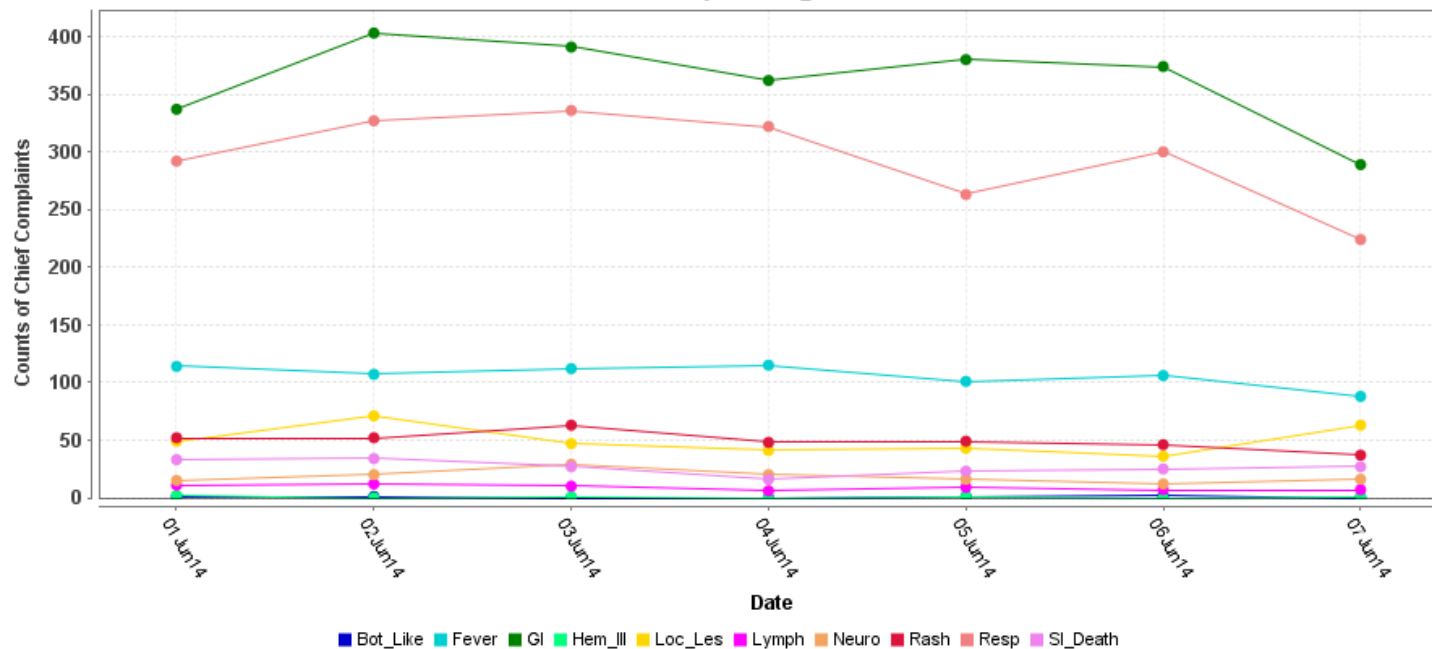
MARYLAND ESSENCE:

Maryland Regions 1 and 2

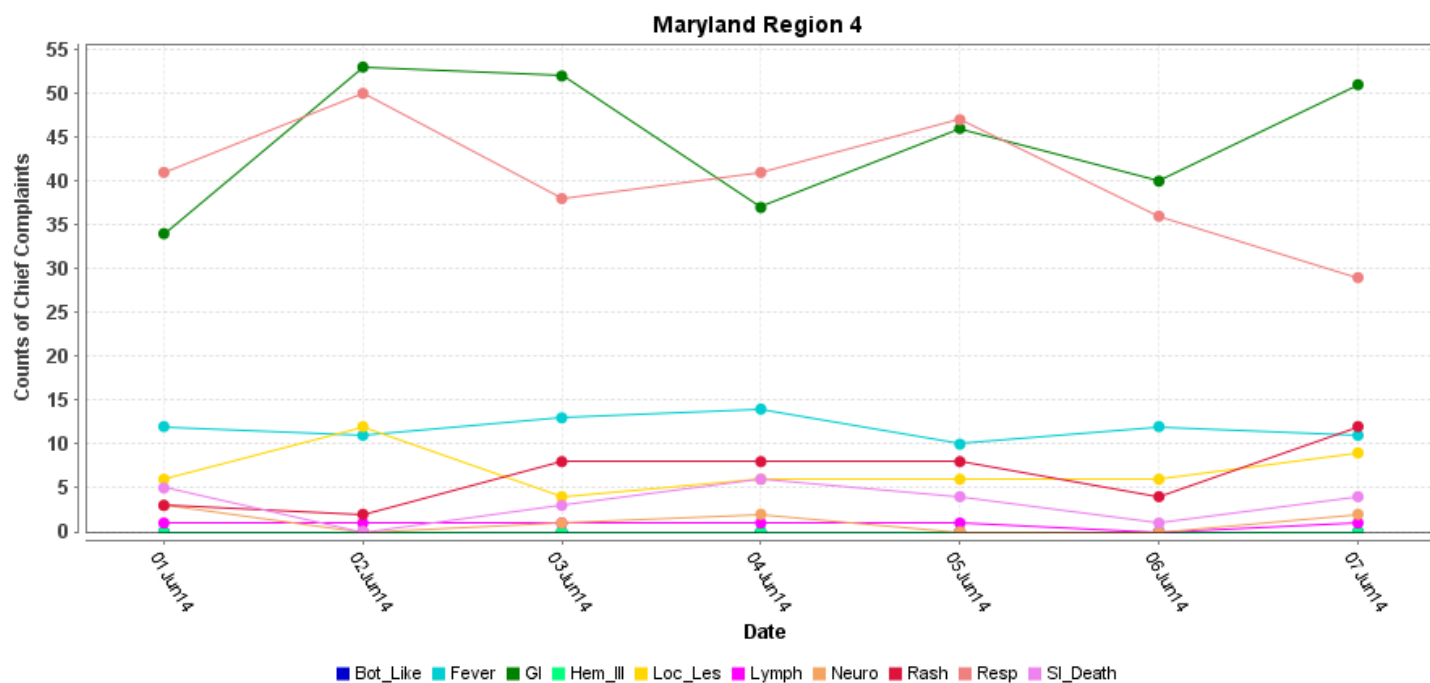


* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE

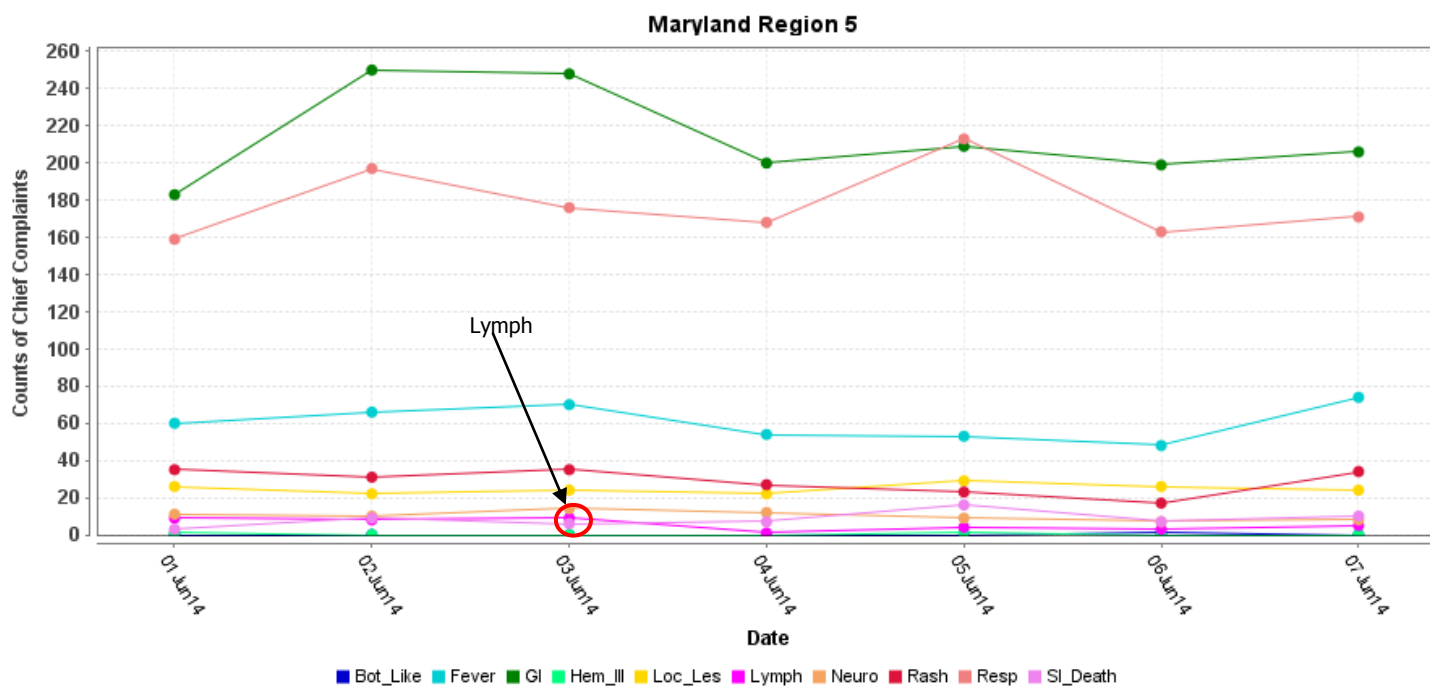
Maryland Region 3



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE

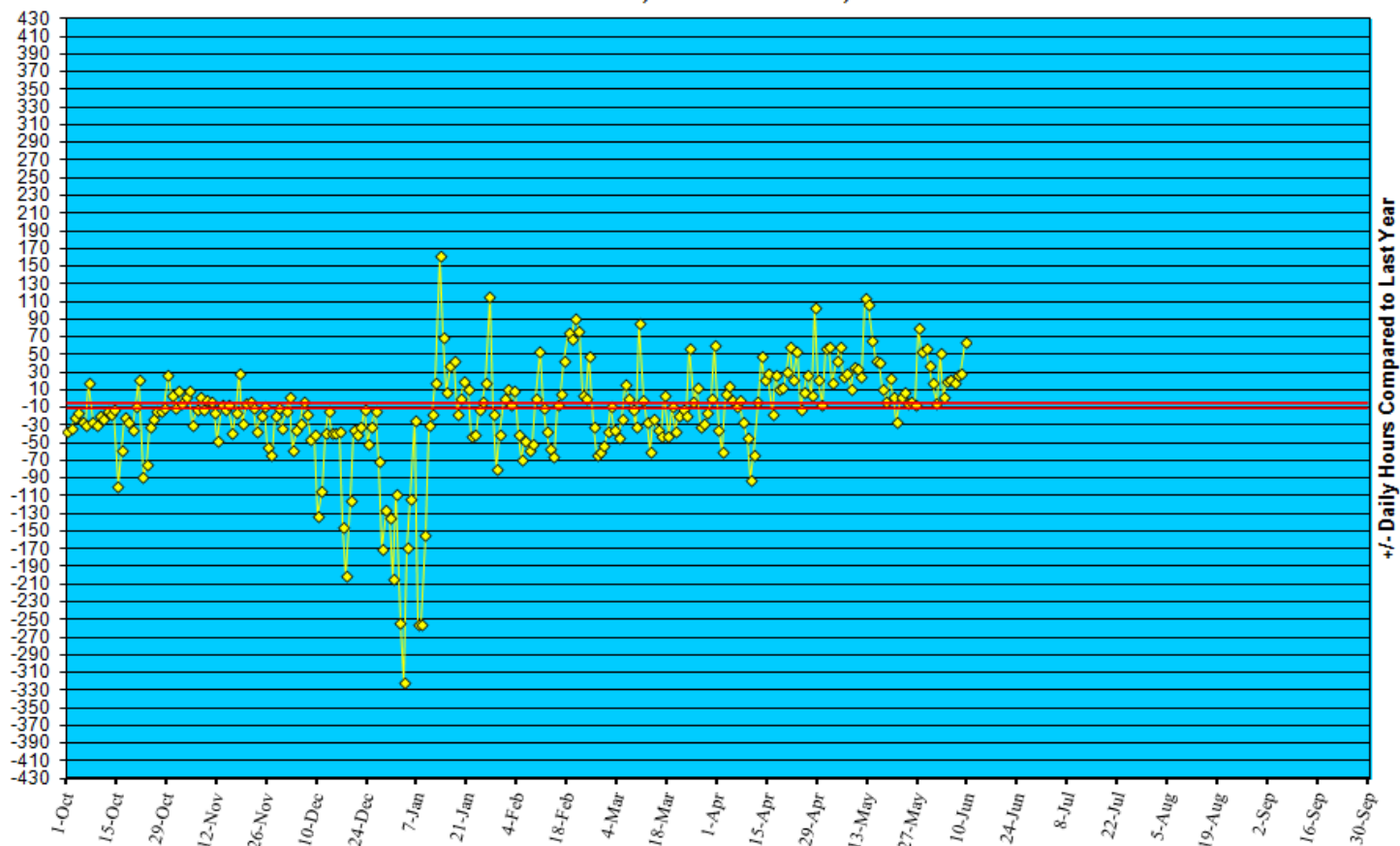


* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.

Statewide Yellow Alert Comparison Daily Historical Deviations October 1, '13 to June 7, '14



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in May 2014 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	<u>Aseptic</u>	<u>Meningococcal</u>
New cases (June 1 - June 7, 2014):	4	0
Prior week (May 25 - May 31, 2014):	8	0
Week#23, 2013 (June 2 - June 8, 2013):	5	0

3 outbreaks were reported to DHMH during MMWR Week 23 (June 1 - June 7, 2014)

1 Foodborne Outbreak

1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Restaurant

2 Respiratory Illness Outbreaks

1 outbreak of PNEUMONIA associated with a School

1 outbreak of PNEUMONIA in an Assisted Living Facility

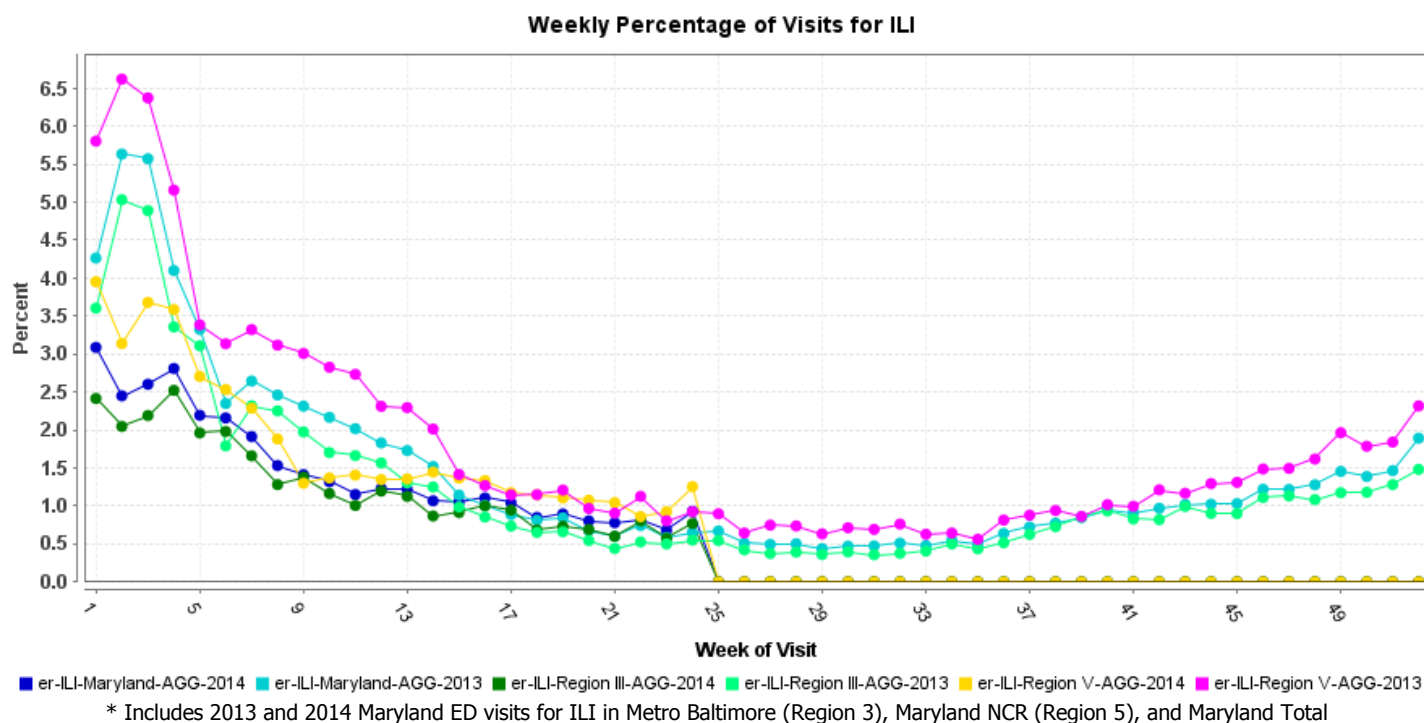
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting generally occurs October through May. The final reporting period for 2014 was MMWR Week 20.

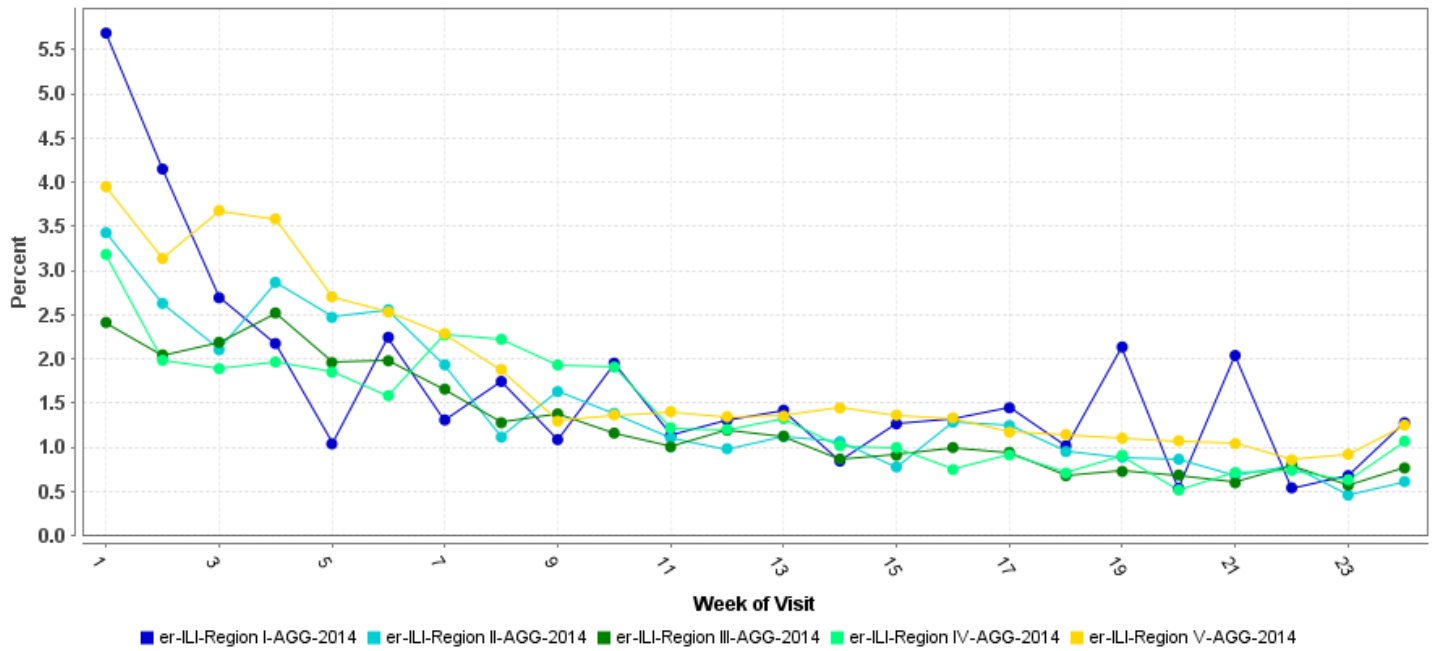
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



Weekly Percentage of Visits for ILI

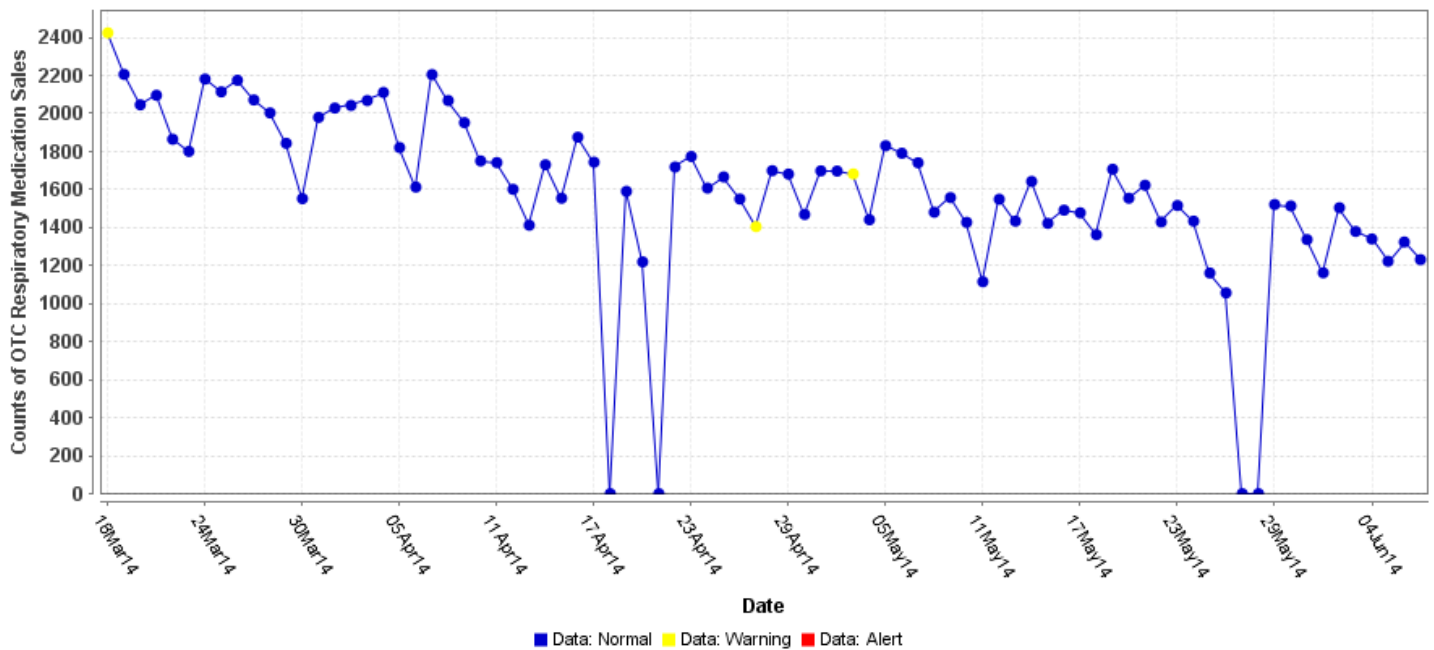


*Includes 2014 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.

OTC Respiratory Medication Sales



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of January 24, 2014, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 650, of which 386 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

NATIONAL DISEASE REPORTS*

E. COLI EHEC (KANSAS): 06 June 2014, A potentially deadly strain of E. coli spreads in Harvey County. "Unfortunately, now we have one new case and we currently have 2 children that are in the hospital," said Skip Cowan with the Harvey County Health Department. Of the 2 children in the hospital, one got sick just last week [week of 26 May 2014] and one has been on dialysis for almost a month now. Health Department investigators say it's been frustrating trying to figure out how this particular strain of E. coli reached its young victims. "Not totally sure what did cause it," said Cowan. "We do not think it was food related at this time." Investigators have spent weeks trying to figure out how the children got infected with a potentially deadly strain of E. coli that attacks the kidneys, causing something called hemolytic uremic syndrome or HUS. In Harvey County they know when and, probably, where the infections started. "It started in the 2nd week of May [2014]. There was a play date that happened here in the county," said Cowan. "And then, a couple days after it happened, people started getting sick." But repeated tests on everything they can think of have turned up no answers as to what caused the infections. "So we're retesting them just to make sure that they're not the source," said Cowan of those at the play date. "You might not be sick or symptomatic, but it's still there." They do know all the children infected attended the same church in Newton. "Now it is ironic they all do go to the church, but as of right now we don't have any reason to think it has anything to do with the church," said Cowan. The church is doing everything it can to prevent any more spread of the bacteria, sterilizing all equipment in the children's areas, cancelling its Bible School this week, and beginning its summer break from Sunday School classes early. Meanwhile, they're asking for prayers for the children in the hospital. The Harvey County Health Department is hoping results from its latest round of tests will provide some answers to this mystery. Those results are expected back from labs in Topeka and Manhattan by the end of this week. (Food Safety Threats are Listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

BRUCELLOSIS, HUMAN (ISRAEL): 07 June 2014, Due to an unusual outbreak of brucellosis in the Western Galilee, the Nahariya hospital [HaZafon (Northern District)] had to treat about 30 patients during the last 2 weeks, half of them children. The patients were found infected by the brucellosis bacterium, known to contaminate cheese and unpasteurized milk from infected animals. The cases have been reported to the Ministry of Health. The bacteria cause a disease known as "Malta fever." The disease is found mainly in the non-Jewish sector in the Galilee [north], Wadi Ara [centre] and the Negev [south]. The Director of the pediatric infectious disease service in the Galilee medical center, Dr. Daniel Glickman, said the patients, arriving during the last 2 weeks at the hospital, are residents of the Druze villages Yarka and Julis, half of them children who consumed unpasteurized cheese; many of them relatives (father and daughter, cousins) who most probably consumed cheese from a common source. "The signs of the disease are usually joint and bone pain, accompanied by high fever. The disease is not contagious among humans and is mainly treated by antibiotics," he said. The patients were hospitalized in the pediatric and internal departments. One case, a 5-year-old girl, had to be hospitalized in the ICU to stabilize her condition. It has been said that the current wave may continue, since the incubation period of exposed persons may take weeks and sometimes even months before clinically manifested. According to the Medical Center, throughout the course of 2013, only 10 patients had to be treated. After questioning by the hospital's doctors, 3 possible sources of infection have been identified. About 10 days ago, another cluster of brucellosis was discovered, in Jerusalem; 14 people were found infected following the consumption of unpasteurized cheese brought from the territory of the Palestinian Authority [West Bank]. (Brucellosis is Listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

EBOLA VIRUS DISEASE (GUINEA): 07 June 2014, Between 2 and 3 Jun 2014, 11 new cases (8 confirmed, 1 probable, and 2 suspected) and 3 new deaths were reported from Conakry (7 new cases and 1 death), Gueckedou (2 new cases and 1 death), Telimele (1 new case and 0 death), and Boffa (1 new case and 1 death). This brings the cumulative total number of cases and deaths attributable to EVD [Ebola virus disease] in Guinea to 344 (laboratory confirmed 207, probable 81, and suspected 56) including 215 deaths. The geographical distribution of these cases and deaths is as follows: Conakry (65 cases and 27 deaths; Gueckedou, 193 cases and 143 deaths; Macenta, 44 cases and 26 deaths; Dabola, 4 cases and 4 deaths; Kissidougou, 7 cases and 5 deaths; Dinguiraye, 1 case and 1 death; Telimele, 23 cases and 5 deaths; and Boffa, 7 cases and 4 deaths. In terms of isolation, 31 patients are currently hospitalized (6 in Conakry, 9 in Gueckedou, 15 in Telimele, and 1 in Boffa). The number of contacts currently being followed-up countrywide is 987 distributed as follows: Conakry (329 contacts), Gueckedou (323 contacts), Macenta (176 contacts), Telimele (104 contacts) and Boffa (55 contacts). (Viral Hemorrhagic Fevers are Listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

EBOLA VIRUS DISEASE (SIERRA LEONE): 07 June 2014, Between 2 and 5 Jun 2014, 9 new suspected cases were reported bringing the total number of EVD clinical cases to 81 (31 confirmed, 3 probable, and 47 suspected) including 6 deaths. Kailahun district is the epicentre of the outbreak in Sierra Leone. 11 cases are currently in isolation at Kenema Hospital. The number of contacts currently being followed-up is 30. Community resistance is hindering the identification and follow-up of contacts. (Viral Hemorrhagic Fevers are Listed in Category A on the CDC List of Critical Biological Agents)

*Non-suspect case

CHOLERA (SOUTH SUDAN): 05 June 2014, The Director General of Health, Central Equatoria State [South Sudan], Dr. Paul Tingwa, says that cholera is still spreading in the state, particularly in Juba Nabari and Rajaf Payams of Juba County, but also to other counties including Yei, Kajo-Keji and Lainya County. In an interview with Radio Tamazuj on Wednesday, 4 Jun 2014, the health official stressed that control of cholera is not the responsibility of the ministry alone, but of every person in South Sudan. He warned residents of west Nile not to drink water directly from the river before boiling, and also encouraged people to follow health regulations as one way of eradicating cholera from South Sudan. Dr. Tingwa said that up to yesterday evening [3 Jun 2014] the cases of cholera have increased to 1138 cases, most of them in Juba itself, the national capital. Another humanitarian official, UN Assistant Secretary-General Toby Lanzer, said that the number was higher than that, putting it at 1209 as of the end of the day on Monday, 2 Jun 2014, citing the "latest consolidated data." There have been at least 29 fatalities so far. Health officials say that those who contract cholera typically have been drinking from unsafe water sources, eating foods sold on the roadside or at makeshift markets, or practicing poor hygiene. One of the hardest hit neighborhoods, Gumbo of Rajaf Payam, which is on the east bank of the Nile just opposite from Juba, saw 164 suspected or confirmed cholera cases between 23 Apr 2014 and 31 May 2014. (Water Safety Threats are Listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

BACILLUS CEREUS, NOSOCOMIAL (ENGLAND): 05 June 2014, A baby has died and 14 are ill with blood infections after being given what appears to be a contaminated batch of liquid food. The babies, many of which were premature, were all being cared for in neonatal intensive care units at 6 hospitals across England. The newborn who died was being treated at London's Guy's and St Thomas's Hospital. The surviving babies are said to be responding to antibiotic treatment. They were all given the liquid nourishment direct to their bloodstream as they could not be mouth fed. Public Health England and the Medicines and Healthcare products Regulatory Agency (MHRA) are investigating. They said as the blood infection, caused by a bacterium known as *Bacillus cereus*, develops quickly they were not expecting any more cases. In a statement, the 2 organizations said: "Investigations with the company have identified an incident that might have caused contamination." An alert has been issued to recall the contaminated product, manufactured by ITH Pharma Limited, from hospitals. The batch expired on Monday, 2 Jun 2014, so should not have been used in the past 2 days. A total of 162 units were sent out from the contaminated batch to over 20 hospitals. The neonatal units that have reported cases are:

- Chelsea and Westminster NHS Trust, London (4 cases)
- Guy's and St Thomas's NHS Foundation Trust, London (3 cases)
- Brighton and Sussex University Hospitals NHS Trust (3 cases)
- Addenbrooke's, Cambridge University Hospitals (2 cases)
- Luton and Dunstable University Hospital (2 cases)
- The Whittington Hospital, London (1 case)

Bacillus cereus is a bacterium found widely in the environment in dust, soil and vegetation. Most surfaces would be likely to test positive for the presence of the bacterium. Microbiologist Professor Hugh Pennington said the bacterium caused food poisoning. "When the bug gets into the bloodstream by direct injection into these very, very frail little babies, that have really got no immune defenses of their own yet, that can be catastrophic," he said. Prof. Mike Catchpole, Public Health England's incident director, said: "This is a very unfortunate incident and PHE have been working closely with the MHRA to investigate how these babies could have become infected. Given that the bacterium is widely spread in the environment we are continuing to investigate any other potential sources of infection. However all our investigations to date indicate that the likely source of the infection has been identified." ITH Pharma managing director Karen Hamling said the company was "very saddened" by the baby's death and was co-operating fully with the investigation. Prof. Ron Cutler, director of Biomedical Science Degree Programmes, Queen Mary University of London, said: "*Bacillus cereus* is widespread in the environment. It is commonly found in the soil. Poorly cooked foods such as rice, which can be contaminated with these spores, are a common cause of food poisoning. Because they form spores, it makes it more difficult to disinfect surfaces and materials contaminated with these spores without using high temperatures and/or powerful disinfectants. In addition, when untreated, spores can survive in environments for long time periods." (Food Safety Threats are Listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX, HUMAN (INDIA): 05 June 2014, The Department of Animal Husbandry has intensified anti-anthrax immunization measures at Thiriyalam and other villages in the Jolarpet block [Vellore district, Tamil Nadu] after a person died in the Christian Medical College Hospital [in Puducherry] on Wednesday [4 Jun 2014], a week after admission for grave sickness brought on by the consumption of the meat of a sick goat slaughtered by its owner. While the hospital diagnosed his disease as human anthrax, the Department did not find evidence of the goat or any other animal in the area having been infected with anthrax, said T Manoharan, Regional Deputy Director of Animal Husbandry. Dr. Manoharan told The Hindu that the goat belonging to a farmer of Thiriyalam, was treated at the veterinary dispensary in the village for indigestion. When its condition turned critical, the owner slaughtered the animal. Many persons consumed the meat. [The patient], aged between 25 and 30, fell sick after he consumed the brain part of the animal in a raw condition. He was admitted to the local primary health centre, from where he was referred to the CMC Hospital on [28 May 2014]. The Deputy Director of Animal Husbandry said personnel of the Animal Disease Intelligence Unit and the Public Health Department conducted a spot survey in the village, but they could not find any evidence of anthrax. The Vellore Collector was informed. All heads of cattle at Thiriyalam and surrounding villages were immunized against anthrax in a drive which commenced on Monday [2 Jun 2014]. "The Department has increased the number of teams and decided to immunize the cattle, goats and sheep not only at Thiriyalam but in all villages within a 10-km [6.2 mi] radius. (Anthrax is Listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX, HUMAN (KENYA): 03 June 2014, More than 2000 in Embu [county] people were yesterday [30 May 2014] given anti-anthrax medicine after they consumed meat of a hippopotamus suspected to have died of the disease. Embu county health director Dr. Philip Masaulo said they are giving mass dosage of anti-anthrax medicine, after one person died while 40 others are recuperating at the Embu Level Five General hospital after eating the meat. Masaulo said at first they targeted 500 people from Kalulu village, near Sagana River where the hippo died, but they went out of drugs after more people came for the same from Kirinyaga, Murang'a, and Machakos. Speaking at Makutano, Mbeere South sub-county, Masaulo said they managed to treat around 1000 people, but promised to go back to the area next week to ensure the remaining people also receive the dose. "We are not taking any chances regarding the lives of all those people who took the meat, we have already lost one person while those with serious symptoms have been admitted," he said, adding that analysis on the blood samples to find out more about what killed the animal are being carried out. Masaulo played down the matter, saying once the dosage is given, the disease will be contained. Benta Wambui, a resident urged Kirinyaga, Murang'a, Embu, and Machakos to unite and ensure anyone who consumed the meat is treated, adding that the meat was shared in Kagio, Kerugoya, and other major towns in Murang'a. She blamed the Kenya Wildlife Service [KWS] officers, for failing to advise the residents over the death of the animal and whether it was fit for human consumption. "We made a mistake to eat the meat without proper inspections, but KWS should have advised us accordingly, there is no way people could not have eaten the meat with the current hunger in the region," she said. Residents have urged the authorities to administer the dose particularly on the school going children to curb any calamity. (Anthrax is Listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: <http://preparedness.dhmf.maryland.gov/> or follow us on Facebook at www.facebook.com/MarylandOPR.

Maryland's Resident Influenza Tracking System: <http://dhmf.maryland.gov/flusurvey>

NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

Zachary Faigen, MSPH, REHS
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: Zachary.Faigen@maryland.gov

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: Anikah.Salim@maryland.gov

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	<p>ACUTE condition that may represent exposure to botulinum toxin</p> <p>ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy.</p> <p>ACUTE descending motor paralysis (including muscles of respiration)</p> <p>ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.</p>	Botulism
Hemorrhagic Illness	<p>SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola</p> <p>ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF</p> <p>ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria</p>	VHF
Lymphadenitis	<p>ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)</p>	Plague (Bubonic)
Localized Cutaneous Lesion	<p>SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia</p> <p>ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia</p> <p>INCLUDES insect bites</p> <p>EXCLUDES any lesion disseminated over the body or generalized rash</p> <p>EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease</p>	Anthrax (cutaneous) Tularemia
Gastrointestinal	<p>ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract</p> <p>SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis</p> <p>ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea</p> <p>EXCLUDES any chronic conditions such as inflammatory bowel syndrome</p>	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	<p>ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)</p> <p>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus</p> <p>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis</p> <p>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain</p> <p>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE <i>acute exacerbation</i> of chronic illnesses.)</p>	<p>Anthrax (inhalational)</p> <p>Tularemia</p> <p>Plague (pneumonic)</p>
Neurological	<p>ACUTE neurological infection of the central nervous system (CNS)</p> <p>SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis</p> <p>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS</p> <p>ACUTE non-specific symptoms of CNS infection such as meningismus, delirium</p> <p>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's</p>	Not applicable
Rash	<p>ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)</p> <p>SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox</p> <p>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem</p> <p>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea</p> <p>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema</p>	Smallpox
Specific Infection	<p>ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)</p> <p>INCLUDES septicemia from known bacteria</p> <p>INCLUDES other febrile illnesses such as scarlet fever</p>	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	<p>ACUTE potentially febrile illness of origin not specified</p> <p>INCLUDES fever and septicemia not otherwise specified</p> <p>INCLUDES unspecified viral illness even though unknown if fever is present</p> <p>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome</p>	Not applicable
Severe Illness or Death potentially due to infectious disease	<p>ACUTE onset of shock or coma from potentially infectious causes</p> <p>EXCLUDES shock from trauma</p> <p>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births</p> <p>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths</p>	Not applicable

D

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmf.maryland.gov